STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Best Care Nursing Services
Petitioner **File No. 21-1497**

v

Citizens Insurance Company of the Midwest
Respondent

Issued and entered
this 19th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On September 22, 2021, Best Care Nursing Services (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Citizens Insurance Company of the Midwest (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on August 16 and 18, 2021 and September 14 and 15, 2021. The Petitioner seeks reimbursement in the full amount billed for the dates of service at issue.

The Department accepted the request for an appeal on October 15, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on October 15, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on November 5, 2021. The Department issued a notice of extension to both parties on December 1, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health aide services rendered on 39[1] dates of service under Healthcare Common Procedural Coding System (HCPCS) Level II code G0156 with a TG modifier for 36 dates of service and G0156 without a modifier for 3 dates of service. The procedure codes at issue are described as home health aide, in a home or hospice setting, each 15 minutes; the TG modifier indicates complex/high tech level of care.

With its appeal request, the Petitioner's submitted documentation included four *Explanation of Reviews* letters issued by the Respondent and a narrative outlining its reason for appeal. The Petitioner stated in its narrative that the "Respondent short paid invoices reimbursing High Tech Aids at only 67% ($[redacted]/hour), which does cover costs associated with [the injured person's] care." In addition, the Petitioner stated:

> The Respondent's reason for reimbursement is: The provider's charge for the service rendered exceeds an amount which would appear reasonable when compared to Fair Health Relative Value HCPCS Benchmark Database…This is in direct violation of the new law which spells out reimbursement for services that 1) use a Medicare code with a fee schedule, and 2) have a January, 2019 Chargemaster…we have met the criteria for NOT receiving a reduction. We have used a Medicare billing code with a fee schedule attached, we have sent our 2019 chargemaster. 2019 rates can easily be verified by the [Respondent] since this is an established rate between us for several years.

In its denials, the Respondent stated that the provider's charge for service rendered "exceeds an amount which would appear reasonable when compared to Fair Health Relative Value HCPCS Benchmark Database." In its reply, however, the Respondent stated that the payment issued to the Petitioner was made based on the application of MCL 500.3157, and its subparts. Specifically, the Respondent stated:

> In this case, the provider charge is for continuous aide care for an individual in their home. Medicare does not provide an amount payable for continuous care in the home, and as such, the provisions of MCL 500.3157(7) provide the methodology of issuing payment; that is, paying 55% of the [Petitioner's] January 2019 charge description master plus a CPI adjustment for the services rendered after July 1, 2021 and before July 2, 2022.

On October 15, 2021, the Department requested that the Petitioner submit its charge description master (CDM). *See* MCL 500.3157(7). The Petitioner submitted its CDM on October 15, 2021.[2]

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[1] The dates of service at issue are July 2, 3, and 4, 2021 under code G0156; and July 19, 2021 through August 29, 2021 under code G0156 with a TG modifier.

[2] The CDM the Petitioner submitted to the Department upon request listed variable amounts for G0156-TG. The Department requested the Petitioner submit documentation in the form of bills and reimbursements from insurers to support an

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

HCPCS Level II Code G0156 with and without a TG modifier has an amount payable under Medicare when it is billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Code G0156 or G0156 with a TG modifier under on a fee-schedule basis because these codes are not priced separately. Where there is no amount payable under Medicare, reimbursement is

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average amount charged on January 1, 2019. The supporting documentation showed that the Petitioner charged $[redacted] per hour for high tech aides with a TG modifier appended. The Department then divided by 4 to calculate the 15 minutes increments billed, resulting in a calculation of $[redacted] per unit.

calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for G0156 and the Petitioner's 2019 average amount charged for G0156 with aTG modifier. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure codes and the dates of service at issue are $[redacted] per unit for G0156, $[redacted] per unit for G0156 with a TG modifier, and a holiday rate of $[redacted] per unit for G0156.

HCPCS code	January 1, 2019 CDM amount	55% of January 1, 2019 CDM amount	4.11% CPI adjustment	Amount payable for the dates of service at issue
G0156	$[redacted]/unit	$[redacted]	$[redacted]	$[redacted]/unit
G0156 (holiday)	$[redacted]/unit	$[redacted]	$[redacted]	$[redacted]/unit
HCPCS code	**January 1, 2019 average amount charged**	**55% of January 1, 2019 average amount charged**	**4.11% CPI adjustment**	**Amount payable for the dates of service at issue**
G0156-TG	$[redacted]/unit	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is entitled to additional reimbursement for procedure code G0156 for the July 4, 2021 date of service at the holiday rate of $[redacted] per unit. In addition, the Department concludes that the Petitioner is not entitled to additional reimbursement for the remaining dates of service at issue.

IV. ORDER

The Director reverses, in part, the Respondent's determination dated September 14, 2021, that the cost of the treatment for the July 4, 2021 date of service in this appeal was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179. The Director upholds the Respondent's determinations dated August 17 and 19, 2021 and September 15, 2021, not to reimburse the Petitioner for the full amount charged for treatments rendered on the dates of service at issue with the exception of the July 4, 2021 date of service.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the July 4, 2021 date of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford